PUBLIC HEALTH: Then and Now

The First Neighborhood Health Center Movement—Its Rise and Fall

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Introduction

AMONG aspects of urban life in modern times which have been regarded as conducive to social dis-ease and decay, the connection between poverty and ill-health has long been recognized as a major focus of community concern and action. Awareness of the widespread prevalence of disease among the poor and of the inadequacy of the health care available to them has at various times motivated efforts to improve their health by providing more effective medical care. Historically, such concern has expressed itself in the creation of programs and facilities ranging from the dispensaries of the 18th century to the current neighborhood health centers.

Indeed, the latter grew out of a recognition that existing arrangements and programs in the United States were not satisfactorily meeting the complex health needs of the poor.[1] As a result, the neighborhood health center has been developed to remedy this situation by providing "a one-door facility, in which virtually all ambulatory health services are available; close coordination with other community resources; professional staff of high quality; and intensive participation by and involvement of the population to be served."[2] In these terms, the current wave of neighborhood health centers has been viewed by some as having brought forth a new institutional form. Yet neither the concept of providing health services on a local basis, nor the creation of facilities to deliver such care, nor the stated objectives of the neighborhood center are essentially new. The concept of a community health center providing service on a neighborhood basis, and its embodiment in organizational forms provided the core for a widespread movement which developed in the United States during the second and third decades of this century, reached its peak during the 30s, and then declined. Since the circumstances out of which this movement grew, the objectives at which it aimed, and the organizational forms it assumed are not unlike those characteristic of the neighborhood health center movement, an examination of the earlier movement may perhaps throw some light on the future possibilities of current trends.

Urbanism, Immigration, and Health

The roots of the health center movement, which began around 1910, are to be found in the changes which occurred in American society during the preceding decades. From 1860 to 1910 the urban portion of the population rose from 19 to 45 per cent of the total, due in large measure to a flood of immigrants which poured into the cities and industrial towns where workers were in demand.[3] From about 1880 the majority of the immigrants came from southern and eastern Europe where they had left the backward, wretched circumstances of countryside and hamlet to seek a better life in the New World.[4] Some were skilled workers and craftsmen, a cate-

gory which was largest among Jewish immigrants, of whom thousands entered the needle trades. A certain number of Italian immigrants also possessed skills adaptable to urban conditions, and some, particularly women, took jobs in the garment industry. Others entered service occupations or set up as shopkeepers or peddlers. As early as 1890, for example, most fruit peddlers and bootblacks in New York City were Italian, and not much later Italians were already heavily represented among waiters, barbers and shoemakers. Most immigrants, however, were unskilled and had to accept poorly paid jobs performing heavy manual work. But even those who were skilled worked excessively long hours for low wages under unhealthful conditions. Frequently they worked for their compatriots, often converting their dwellings into sweatshops.

Separated from the native Americans by language and custom, the immigrants crowded together in segregated neighborhoods where mutual aid and understanding were available. These neighborhoods were a geographic expression of the immigrants' endeavor to maintain their identity by living within a cultural environment in which they had roots, and from which they might make contact with and learn about the unfamiliar American world in which they found themselves. To the native American, however, the areas where these impoverished aliens congregated were loathsome, sickening slums whose denizens challenged and threatened the fabric of his social and psychological order. As early as 1883 Henry George, anticipating the end of the public domain viewed the flooding immigrant tide with alarm and asked "What in a few years are we to do for a dumping ground? Will it make our difficulties the less that our human garbage can vote?"[5] George was not alone in his opinion, which was echoed with numerous variations in succeeding decades. Robert A. Woods, a leading Boston social worker of the period, recoiled from the "unspeakable degraded standard of life" of the immigrants, while his collaborator Joseph Lee was amazed that this "human rubbish" produced a "number of physically, mentally and morally efficient citizens."[6]

The revulsion and dismay expressed in such statements are related to two reactions to the immigrants which clashed in principle but in practice tended to blend in various, sometimes ambiguous ways. One was a reaction to the differing life-styles and values of the immigrants, comprising feelings of contempt, distrust and fear, as well as a sense that the alien masses were inferior and a menace. General anti-foreign attitudes, views of foreigners as unruly and dangerous were refracted through specific ethnic or national stereotypes to which unfavorable characteristics and qualities were attributed.[7] This attitude found its more unsophisticated expression in the tendency to single out "wops," "sheenies," "polacks," "bohunks" or some other group as inherently criminal, avaricious or subversive.

But even those Americans who were sympathetic to the foreign-born were not completely exempt from the influence of the current stereotypes. In the early 1900s, the distinguished physician, Richard Cabot, examining his reactions to foreign-born patients at the Massachusetts General Hospital, noted that "the chances are ten to one that I shall look out of my eyes and see, *not* Abraham Cohen, but *a Jew* . . . I do not see *this* man at all. I merge him in the hazy background of the average Jew. But," he went on, "if I am a little less blind than usual to-day . . . I may notice something in the way his hand lies on his knee, something that is queer, unexpected. That hand . . . it's a muscular hand, it's a prehensile hand; and whoever saw a Salem Street Jew with a muscular hand before? . . . I saw *him.* Yet he was no more real than the thou-

sands of others whom I had seen and forgotten,—forgotten because I never saw *them,* but only their ghostly outline, their generic type, the racial background out of which they emerged."[8]

Cabot's self-analysis is an aspect of the other reaction to the immigrants, an aspect of an endeavor to come into close enough contact with them to learn about them as people, to begin to understand the stresses and strains to which they were exposed in an alien environment. This tendency appeared most prominently with the establishment of social settlements in the 1890s in the poorest sections of Chicago, New York and other cities. Since these sections, the slums, were also overwhelmingly the foreign quarters, most of those with whom settlement dwellers worked were immigrants. The settlement workers soon became aware of the deep gulf which separated the poor immigrants from the larger society in which they lived, but to which they did not belong. Recognizing the need for social integration of the newer immigration with the older America, they set themselves the task, as Lillian Wald put it, of "fusing these people who come to us from the Old World Civilization into . . . a real brotherhood among men."[9]

For the most part, the settlements approached this task in practical, concrete terms. Recognizing that the influences to which the immigrants were subjected, and the treatment which they received after arrival, resulted in exploitation and neglect, they endeavored to prevent or repair the damage by turning to social action and dealing with specific problems such as economic exploitation, overcrowded and decrepit housing, destitution, broken homes, crime, alcoholism, prostitution and ill-health. The settlement dwellers worked largely on a local basis, directing their efforts and programs specifically at immigrant needs, at the needs of an oppressed minority. In so doing, they planted the seeds of a national social welfare program but their immediate concern was the neighborhood. This positive interest in the welfare of the immigrant poor went hand-in-hand with a desire to work with them, as well as for them, and also with a growing awareness that by accepting the cultural heritage and enhancing their self-respect, the slum dwellers were more likely to become involved in solving or ameliorating the problems of their group and their neighborhood.[10]

The great importance of health problems within this complex context was well-recognized. In 1909, Edward T. Devine,[11] a leading social worker, noted not only that "Ill health is perhaps the most constant of the attendants of poverty," but he went on to emphasize that "An inquiry into the physical condition of the members of the families that ask for aid . . . clearly indicates that whether it be the first cause or merely a complication from the effect of other causes, physical disability is at any rate a very serious disabling condition at the time of application in three-fourths . . . of all the families that come under the care of the Charity Organization Society, who are probably in no degree exceptional among families in need of charitable aid."[12]

Activities in New York and Chicago also are indicative of the importance attached to health work among the poor immigrants. In 1893, Lillian D. Wald and Mary Brewster opened the Nurses' Settlement on Henry Street in New York in order to bring the benefits of public health nursing to an entire neighborhood. The Henry Street Settlement developed an organized community service intended to prevent disease, as well as to help the sick. As its program grew, involvement in studies of health and social welfare extended the influence of Henry Street far beyond the locality.[13]

Also in 1893, four years after Jane Addams opened Hull House, a public dispensary was organized at the settle-

ment in Chicago. It was open every day from three to four in the afternoon and from seven to eight in the evening. There was also a physician in residence at Hull House, and another doctor who lived nearby helped out. A nurse from the Visiting Nurses' Association was stationed at the settlement, and received her orders there. In addition, various studies and programs were undertaken to improve health conditions in the neighborhood where the settlement was located. These involved improvement of housing and garbage collection, combating cocaine addiction among minors, regulation of midwifery, studies of tuberculosis in relation to overcrowding, and of typhoid fever and poor sanitation.[14]

Thus, throughout the last decades of the 19th century and the early years of this century, the growing cities of the United States were increasingly confronted by the problems of poverty, crime, disease and other attendant ills of the slums, problems most often associated with immigration.[15] The inescapable fact of these urban problems, plus a growing conviction of the need for social change led to a broad movement of reform dedicated to the eradication of demonstrable social ills and the realization of conditions for a better life through planned social action. From this standpoint campaigns were mounted to deal with a wide range of problems: poverty and dependency, tenement house reform, sweatshops, prostitution, juvenile delinquency, and others among which ill health was prominent as a cause or a consequence.[16]

Coordinating Health Work

While these changes were taking place, the work of Pasteur, Koch and their contemporaries had been answering some of the pertinent questions concerning the causation and prevention of communicable diseases, and this knowledge was being applied in public health programs. As a result, by the end of the first decade of this century, there was a solid basis for the control of a number of infectious diseases and throughout succeeding decades advances along this line continued.[17] Alongside these trends, a shift was beginning to take place in the concept and orientation of community health action, a shift of attention from the environment to the individual. As health authorities and others became aware of noxious influences, other than those emanating from the physical environment, as activities in connection with maternal and child health, industrial hygiene, tuberculosis, venereal disease and mental ill-health developed, public health expanded. As new areas of concern became a part of public health, new programs developed and new personnel were trained to execute them.[18] Increasing expansion of the scope of community health work created problems for official and voluntary health agencies. As more and more special programs, operated by separate personnel and often through special agencies, came into being, it also became increasingly clear that better ways of organizing and administering health work were needed.[19] It was recognized that there was a need for the coordination of hitherto separated agencies, facilities and services, many of which were concerned with the same population. Even within a single agency (such as a large urban health department), duplication of effort and lack of coordination among its constituent units were found both wasteful, inefficient and irritating to the people who needed the services. In 1914, S. S. Goldwater, the Health Commissioner of New York City, observed that "Various brueaus send their representatives into the same districts, often into the same house, which results in undue expenditure of time and energy and in annoyance to the individual citizens."[20] A similar point of view was expressed by Charles F. Wilinsky in

Boston. . . . "Gaps in the programs," he said, "duplication and consequent waste, frequent inefficiencies and misunderstandings, could not help but lead to the conclusion that there was a great need for better coordination and correlation, more efficient organization, and more harmonious understanding between those agencies concerned with the public health and with the amelioration of human suffering." He went on to add "that the fault of public health administration in large cities particularly was due to the fact that it was too far removed from the people it attempted to serve."[21]

Wilinsky's last remark touches on another factor which reinforced the tendency to develop local health work, namely, recognition that effective application of health programs, especially among the poor and the foreign-born, required an approach to the people on their own ground, in their neighborhood. By locating a service in the section where they lived, one avoided the necessity of drawing these people away from familiar streets and landmarks. Strangeness and distance, as well as language barriers and long waiting periods, were serious limiting factors in the use of health facilities such as dispensaries and hospitals.[22] As Michael M. Davis pointed out, long waits were particularly important for mothers, "when children must either be brought along or left at home in the care of a busy neighbor, or of children too young to take the responsibility."[23] Moreover, "the mother in her home, seldom, if ever, getting out to gatherings of any sort, is the hardest member of the immigrant group to reach, and often the slowest to give up her racial habits; yet in her position as homekeeper she has most to do with the health of her family. Taking our health work into her neighborhood is the surest way to get acquainted with her."[24]

Nevertheless, even such a localization of health and social services was not enough as long as the prospective users, the consumers, confronted a multiplicity of uncoordinated agencies in a situation where they were Alices in a Wonderland of confusing community resources. About the time of the First World War, in East Harlem, in New York City, for example, there were many clinics, dispensaries, and district offices of welfare agencies, but the ordinary citizen had only the vaguest idea of what they did, what services they provided. Nor did he have any more precise notion of the service he needed. "He might be in trouble of some kind," wrote Homer Folks, "his health failing, or one of the children backward at school, or running afoul of the police, or the family just could not make ends meet. He needed assistance badly, somewhere, from somebody, but just what sort of help, or where to go to find it, or whether it could be had, were vague uncertainties . . . Possibly he remembered having seen a sign somewhere in the locality or someone had told him that somebody had said that someone had been helped from an office on the north side of 116th Street near First Avenue. If of an optimistic and pioneering type, he bravely started on a voyage of discovery of what we call the social resources of the community.

"If his courage were strong, and his health not too bad, the needy person might persevere and by making the rounds, calling, on one office and clinic after another, and being referred from one agency to another, he might finally arrive at the place where he should have gone in the first instance for real help for his particular trouble." The consequences of this situation were frequently deplorable; ". . . the fact of not knowing just what was needed, nor just where to go, resulted on the part of the less enterprising, in not going anywhere. And, going nowhere and doing nothing meant that things went from bad to worse."[25]

An implicit consequence of this statement is that health and welfare agencies should, as far as possible, be brought together, perhaps under one roof. As settlement workers had already recognized, the problems for which poor people needed help were usually neither simple nor single and had no easy solutions. More often than not their health and social problems were closely linked, so that those endeavoring to solve them had to establish the closest possible collaboration. This point was explicitly underscored by Robert A. Woods. "The local health center," he wrote, "gathers under one head a group of services which in greater or lesser degree have been undertaken in the past by the settlement. In all their technical phases the settlement clearly and unquestionably must be ready to pass them over to the health center. It is, however, equally clear—and this the promoters of the health centers do not always appreciate—that all the values of acquaintance and influence which the settlement has in its various organizations—must continue to be of indispensable importance to any sort of comprehensive local health campaign."[26] With this comment Woods touched upon another important dimension, the sociopsychological. Unless geographic localization and administrative coordination were complemented by social organization of the neighborhood with active participation of the population served, the fullest benefits of localized services would not be achieved. What was needed was a democratic educational process involving local people on an organized basis.

This aspect was most fully developed by Wilbur C. Phillips and his wife Elsie Cole Phillips.[27] The initial source for his idea of a community health plan was his experience as secretary of the New York Milk Committee established in 1907 by the Association for Improving the Condition of the Poor.[28] The objective of the Committee was to reduce infant mortality in New York City by improving its milk supply, and seeing that babies received clean milk. Phillips undertook to achieve this aim by establishing infant milk depots throughout the city. This in itself was not new; the philanthropist Nathan Strauss had begun to establish a system of milk stations in 1893.[29] However, Phillips soon recognized that distribution of milk was not enough. Stimulated by the work of Pierre Budin, professor of obstetrics at Paris who, in 1892, established a system of infant consultation centers, and based on his own experience, by 1909, Phillips had developed a concept of the milk depot as a "centre of influence for child life" where babies could receive medical examinations, where mothers could be taught how to keep their babies well, and from which would "radiate the influences of education and social betterment."[30]

The First Health Centers, 1910–1919

In 1911, this idea was expanded by Phillips in a Polish district of Milwaukee into a demonstration center for maternal and child care on a broad democratic basis using a so-called "block plan."[31] After resigning from the New York Milk Committee in 1910, he left for Milwaukee where implementation of his idea appeared feasible. Milwaukee had a high infant mortality, and seemed ready to deal with such problems in terms of basic social change, since it had recently elected a Socialist administration to office, the first large American city to do so. Phillips was then a member of the Socialist Party, having joined because as he says, "I knew at that time no other way of registering my opinion that poverty could and should be abolished—and that it could not be abolished through charity. But first, as the Socialists preached, came education—getting wider and wider numbers of people to understand the root causes of poverty and the way to remove them."[32]

In May, 1911, at the instigation of Phillips, a non-partisan Child Welfare Commission was appointed of which he became secretary. Its objective was to investigate the causes of infant mortality, and to formulate and carry out a plan of child welfare work from the standpoint of the entire community. By the end of the year the studies had been completed and a child health program based on a system of preventive health centers was proposed. This program was to be carried out by the municipality through its health department which would direct the work of social organization, promotion and education that was regarded as absolutely essential for the development of the child health program, and which the Phillipses had been doing. As a demonstration, they set up a child health station in a Polish area, comprising 33 city blocks with a population of 16,000 people and between 350 to 400 mothers and babies. The medical staff to provide the preventive consultations was selected by the physicians of the district, who also agreed on a fixed fee of $2.00 to be paid each doctor for his period at the clinic. Cooperation of midwives and other local people was obtained. An unprecedented degree of support was obtained from the mothers by the creation of block committees headed by a block worker for each of the blocks in the demonstration area. This was the germ of the social unit idea which Phillips was then to try and implement in Cincinnati.

This was in the spring of 1912, but by June of that year, Wilbur Phillips and his wife were on their way to New York. Their activities had been upset by a change in the municipal administration. The Child Welfare Commission was terminated, and the child health program was limited to its purely medical aspects as part of a health department activity. But the idea of an "Educational Health Center" had been formulated, an idea which was to provide the basis for the Social Unit Organization, which in 1917 took form under Phillips' leadership in the Mohawk-Brighton district of Cincinnati. This was undertaken as a demonstration of the National Social Unit Organization created by Phillips in 1916, with headquarters in New York City. The purpose of this group was "to promote the type of democratic community organization through which the citizenship as a whole can participate directly in the control of community affairs, while at the same time making constant use of the highest technical skill available."[83]

After some deliberation, the Mohawk-Brighton district of Cincinnati was chosen for the purpose of carrying out a "social unit" community experiment on a large scale, and funds were made available by the national organization for a period of three years, with a certain proportion of the budget to be raised in Cincinnati. This city was chosen in large measure because Courtenay Dinwiddie, secretary of the Cincinnati Anti-Tuberculosis League (realizing the importance of community organization) worked hard to have the demonstration there. The League had developed plans in 1917 for a neighborhood health center through which its aims might be attained, and now felt that the Social Unit Plan was capable of achieving even more than their initial goals.

The demonstration was carried out in a neighborhood of some 15,000 inhabitants, of whom between 5 and 10 per cent were recent immigrants.[84] The area was divided into thirty-one "blocks" of approximately 500 people each, and in each block, the residents over 18 years of age elected a council. This council elected a block worker who represented the residents of the block on the Citizens' Council of the Unit. Her duties were to visit the families in her section, keep them in touch with the Unit, and to bring specific problems they had to the proper department of the organi-

zation. The block worker was paid four dollars a week for the time lost from her household activities. Just as the Citizens' Council represented the people of the district, an Occupational Council secured the interest and cooperation of the various occupational and professional groups in the district, while the doctors, nurses, and social workers had their groups for the consideration of problems involved in their work. The Occupational Council was a neighborhood planning body working with other groups in the city. No new activities were undertaken until they had been endorsed by the people of the district through their representatives on the various councils. Most of the health and welfare agencies in Cincinnati, not only the Anti-Tuberculosis League, but also the Associated Charities, the Better Housing League and the Humane Society, cooperated with the Social Unit Organization.

The Cincinnati Social Unit demonstration was an experiment in applied democracy with health as its focal point. The health activities carried on included antepartum care, well child care for infants and pre-school children, anti-tuberculosis work, dental examination of school children, nursing service, medical care during the influenza epidemic of 1918, and periodic examination of adults. In short, beginning with health as a field of activity, Phillips and his coworkers endeavored to develop a consciously self-governing local unit in the midst of a large city. This enterprise was one of the most seminal experiments in social organization for health in the United States. It offered a vision of a community in which citizens working together as members of a vitally cooperating group sought the common welfare rationally and intelligently. It also raised profound political and social questions which are still unresolved. Can such a vision be realized in the heart of a large urban center? Can its inhabitants become truly conscious of mutual interests and be, in some degree, self-governing? Do such aims require a stable population, and how can such stability be maintained?

The Cincinnati experiment answered some but not all the questions. Opposition to it developed from the Director of Public Welfare, the newly elected Mayor, a local medical society and various conservatives who charged that the Social Unit demonstration was a Red plot, a not uncommon occurrence in the supercharged patriotic atmosphere at the end of the First World War. Although an investigation of the charges showed that they were unfounded, and a referendum within the Mohawk-Brighton district revealed a strong sentiment for the demonstration, the municipal administration withdrew its support, the funds that had been pledged were not forthcoming, and by 1920 the Social Unit demonstration was over. Without political and economic leverage, the inhabitants of the district could hardly make their wants felt. Phillips had not adequately established a financial basis nor had there been adequate time to create a political power base. The demonstration raised questions but provided only partial or ambiguous answers.

Meanwhile, efforts had been made elsewhere to provide health services to a definite population on a local basis. In 1912, William C. White, a physician and medical director of the Tuberculosis League of Pittsburgh, tried such an approach to tuberculosis control. As his model, he took the district system of the public schools. "In the educational field," he said, "there has gradually developed a knowledge of the equipment necessary for a given population, and this equipment has been apportioned so as to be readily accessible to those whom it is to serve. The management of these units is centered in a legally constituted governing body which also controls the expenditure of funds collected by taxa-

tion. The same form of control is applicable to tuberculosis and other health problems."[35] However, White's scheme lasted only six months. That year also saw an effort in Philadelphia by Samuel M. Hamill, a physician, to apply the same idea to child health work creating a basis for a growing program. Broader and more enduring efforts were also undertaken in New York, Boston and Buffalo.

In 1913, the New York Milk Committee established a health center on the lower West Side of Manhattan to serve a district populated largely by Syrians and Irish-Americans, where housing was poor and medical resources were limited.[36] The Bowling Green Neighborhood Association composed of local residents and outside specialists was formed to administer the center which provided chiefly antepartum and infant care. Neighborhood associations composed of voluntary groups of citizens were not new in New York City and many of them had worked with the Health Department in one way or another.[37]

S. S. Goldwater, Health Commissioner of New York, was aware of these developments and in September, 1914 formulated a plan to apply the principle of localization to health administration in order to see how far the work of the Department could "be improved by the substitution of a system of local or district administration for the present purely functional administrations."[38] To answer this question an experimental health district was established by January, 1915 on the lower East Side of Manhattan in an area populated almost entirely by Jews.[39] The district comprised a highly congested area of twenty-one blocks housing 25,000 people. The staff comprised a part-time district health officer in full charge of local administration, a part-time medical inspector who was responsible for medical inspection of preschool and school children as well as the infants' milk station, three nurses and one nurses' assistant, a food inspector and a sanitary inspector, both part-time. The basic principles underlying district work were coordination of health department functions, local administration in terms of local needs, and establishment of a community spirit. In accordance with the latter point, the health officer of the district was a Jewish physician who understood the people, their language, backgrounds and characteristics.

The experiment proved so satisfactory that on May 1, 1916 it was extended by Haven Emerson, (Health Commissioner from 1915–1917), to Queens, where four health districts were opened (Long Island City, Flushing, Ridgewood and Jamaica). In 1916, there was also created within the Health Department a Division of Health Districts under the Deputy Commissioner of Health, and in 1917 the district health officers were placed on a full-time basis.[40] Unfortunately, at this time, there was a change in the city government, and the new administration slipped smoothly back into the established rut of the *status quo ante*. Among other actions, it halted the plans to extend district health administration to other parts of the city, and it was not until more than twelve years later that district health centers were established on a more solid basis in New York. Nevertheless, experience had been gained for such a program, and some advantages to be derived from decentralized public health administration were demonstrated. For example, as a consequence of the coordination of services, it was possible to serve families more efficiently, with all services rendered to a family provided by a single nurse. This led to the introduction of a Family Record Card which contained a continuous history of the family as far as Health Department services were concerned. However this abortive attempt to apply the principle of local administration to health work in New York

City brought forth a problem which was to plague the revived district system in 1930s, namely, the division of responsibility and the relationships between the district health officers and the chiefs of the central functional bureaus of the Department.

During this period, health departments and private health and welfare agencies in a number of American cities and towns undertook to coordinate their activities on a localized basis and to develop neighborhood health centers and programs. In 1916, on the initiative of Charles F. Wilinsky, Deputy Health Commissioner of Boston, (who has been referred to above), the Blossom Street Health Unit was opened in the West End, one of the most congested sections of the city.[41] The objective was to provide a local center from which agencies engaged in health and welfare work could serve a geographically defined population. Among the agencies included in the center were the Consumptives Hospital Department, the Instructive District Nursing Association, the Milk and Baby Hygiene Association, the visiting physician of the Boston Dispensary, and the Hebrew Federated Charities. Later additions were clinics for dental care and mental health counseling. Eventually, Boston had eight centers, each serving a population of 50,000. This expansion was assisted by a bequest by George Robert White of six million dollars to the city of Boston for this purpose.

Similar developments occurred in other large cities. Beginning with one experimental station in 1914, Buffalo developed a citywide system of district services. By 1920 there were seven districts of 26,000 to 91,000 population (average about 75,000) with a center in each. The system represented a cooperative arrangement between the Department of Health and the Department of Hospitals and Dispensaries. Arrangements and proceedings were also worked out to govern relationships with private medical and social agencies. Basically this system was intended for the poor people of the city, and the districts were correlated with the existing tracts covered by the Charity Organization Society.[42]

Health Centers Spread

As C.-E. A. Winslow noted in 1919, "The most striking and typical development of the public health movement of the present day is the health center."[43] The First World War had emphasized the possibilities of coordinated effort in achieving results, as well as the importance of health, and these lessons were not lost on community leaders. When the War ended, health centers and demonstrations financed by foundations, voluntary health agencies, or other social welfare organizations, as well as by local governments were established in many parts of the United States. A decision by the American Red Cross at the end of the War to further the establishment of health centers gave additional impetus to this trend.[44] Local chapters undertook to create health centers, and more generally such facilities became the fashion in community health work.

The scope of this development is evident from the following figures obtained by the Red Cross during the latter part of 1919 in a survey of existing and planned health centers.[45] The report showed that as of January 1, 1920 there were 72 centers in 49 communities, of which seven cities had more than one center. In addition to the existing centers, 33 centers were being proposed or planned in 28 other communities. An analysis of the existing and proposed centers showed that at the time of the report, 33 were administered entirely by public authorities, 27 were under private control, and 16 were under combined public and private control. The Red Cross was involved in 19 instances. There was considerable variation in the work

and aims of the existing health centers. In 40 communities with health centers in operation, 37 contained clinics of some type, 34 carried on visiting nursing, 29 did child welfare work, and 27 did anti-tuberculosis work. Twenty-two had venereal disease clinics, 14 had dental clinics, and 11 had eye, ear, nose and throat clinics. Only 10 had laboratories, and nine had milk stations.

The succeeding decades witnessed a further development of health centers and districting of health services. In 1930, a subcommittee on health centers collected information for the White House Conference on Child Health and Protection. It obtained data for 1,511 major and minor health centers throughout the United States. Eighty per cent had been established since 1910. Of the total number, 725 were operated by private agencies, 729 by county or municipal health departments, and a small number by the Red Cross, hospitals, tuberculosis associations, case-work agencies and the like. In nearly half these centers, the principal support came from public funds, while supplementary aid came through community chests, or from private funds.

As is not infrequently the case when a professional development or trend is in "fashion," the name by which it is designated acquires an aura of approval, and is used to describe activities and enterprises that differ widely, so that they may share some of the aura. This was also the fate of the health center concept, and is in part responsible for its decline. As one observer put it in 1921, "We find it used as a name for child welfare stations, tuberculosis dispensaries, venereal disease clinics, out-patient departments of hospitals, settlement houses, and substations of local health departments."[46] The Red Cross concept of a health center was that of an institution which could be locally operated with a minimum of outside direction and with an emphasis on its function as an educational, informational facility. "Functionally, the health center is an institution through which the community may get in touch with all health promoting agencies and with the health problems of local and of national importance."[47] Administratively, however, the Red Cross view was that the health center should be under the combined guidance and control of all the local health agencies.

Michael M. Davis, writing in 1927, defined the health center more definitely and related it more specifically to health care, both preventive and curative. "Observation of a large number of health centers," he said, "leads to an indication of two factors which all those studied appeared to present: first, the selection of a definite district, or of a population unit, with the aim of serving all therein who need the services offered; second, coordination of services within this area, embracing both the facilities furnished by the health center itself and those provided by other agencies. A definition might therefore be stated as follows: A health center is an organization which provides, promotes and coordinates needed medical service and related social service for a specified district."[48] Davis also emphasized that there were still many unanswered questions concerning policy, objectives, organization, administration and evaluation of health centers. For example, he asked, "How far is organization of the people of a district themselves a practical means of promoting the services at the center, and of advancing health education throughout the district? Experience shows great value in a loose local organization of agencies interested in medical or health work, in education, especially public and parochial schools, and neighborhood and recreational bodies. On the other hand, the attempt to organize the people of a district into a local council, with or without block workers, has generally yielded little result in proportion to the effort expended. The reasons for this

difficulty lie deep in the characteristics of American neighborhood life, whether among native or foreign-born."[49]

Meanwhile, significant district health programs were created and developed in a number of American communities. It is obviously impossible to discuss those developments in detail, but several selected examples can indicate some of their characteristics. In New York City a program of district health administration was developed after 1929, and a group of health centers was opened beginning with one in rented quarters in central Harlem. Actually, this program grew out of two demonstrations in the 1920s. The East Harlem Health Center was initiated in 1920 by the New York County chapter of the Red Cross, and was opened in November, 1921. The demonstration was planned as a three-year project involving the cooperation of the Health Department and 21 voluntary agencies, and was described as a "department store of health and welfare,"[50] where clients could find under one roof almost all the health and welfare services needed. Throughout the decade the Health Center continued to develop, and eventually became one of the municipal district health units. While East Harlem was the first general health center, the Bellevue-Yorkville Health Demonstration, organized in 1924 and opened to the public in 1926, led eventually to the adoption by New York City of the principle of district health administration.[51] Financed by the Milbank Memorial Fund and the Health Department, the Demonstration was carried on for ten years in cooperation with a very large number of participating official and voluntary agencies.[52] With the example of two health centers in operation, and under pressure from leaders in the private health and welfare field, the Health Department developed a citywide plan of district administration, with a health center building in each district serving as a local headquarter for both private health and welfare agencies and for the field activities of the Department. In 1934, under the administration of Fiorello H. La Guardia, the city embarked on a program of districting which has had its ups and down over the years—but is still in existence at present. Owing to changing policies and intramural conflicts the potential of this system was never fully realized.

Plans initially started by William H. Welch in Baltimore in the twenties eventuated in 1932 in the establishment of the Eastern Health District as a cooperative endeavor of the Baltimore City Health Department, the Johns Hopkins School of Hygiene and Public Health, as well as several voluntary agencies. This district has made possible the intensive study of public health problems and has provided a field laboratory for the testing of new administrative procedures and for the training of personnel. A second district was organized in 1935.

The district health center, coordinating hitherto separated clinics and services, was inaugurated to replace centralized control of particular services. Generally, the health center has been a branch or unit of a local health department or some other official health agency. Except for such diseases as tuberculosis, venereal diseases and a few other conditions considered as public health problems, most medical care concerned with diagnosis and therapy remained outside the sphere of activity of health centers, which emphasized prevention. Farsighted leaders in the health field realized that the health center concept might be employed to improve the organization and provision of medical care, issues which had come to the forefront of public attention at the same time as the health center. The Social Unit experiment in Cincinnati had touched on this problem, as did J. L. Pomeroy, the County Health Officer of Los Angeles, in his ambitious program undertaken in

1919.[53] In his centers, Pomeroy originally included clinics staffed by physicians, nurses and social workers to provide preventive and curative services on an ambulatory basis. The clinics were available to the poor whose eligibility was established by a means test. Due largely to the complaints of physicians that medical care was being given to patients who should go to private practitioners, by 1935 this work had, for the most part been turned over to the Welfare Department and the county general hospital. This attempt foundered on the slogan that undeserving individuals were abusing the service intended only for the indigent, a theme which has been played with variations for about one hundred years.[54]

The most imaginative approach was made by Hermann Biggs in 1920 when he endeavored to deal with health service for rural areas in New York State.[55] As Commissioner of Health, he proposed the establishment of local health centers to include one or more of the following elements: hospital, clinics (for tuberculosis, venereal diseases, prenatal and child care, mental illness, dental care, and general medical care), laboratories, public health nursing, and district health administration. Such centers could be established in any county with the approval of the State Health Commissioner. The proposal was permissive and not mandatory in any of its details. In addition to coordinating public health services, these centers were intended "to encourage and provide facilities for an annual medical examination to detect physical defects and disease;" and "to provide for the residents of rural districts, for industrial workers and all others in need of such service, scientific medical and surgical treatment, hospital and dispensary facilities and nursing care at a cost within their means or, if necessary, free." State aid in the form of 50 per cent cash grants for buildings, a cash allowance for the treatment of patients unable to pay, together with certain allowances toward maintenance, were to be furnished to all communities fulfilling the requirements of the State Health Department. While a large number of community organizations supported these proposals, the Sage-Machold Bill which embodied this health center program, was defeated in the New York Legislature. The whole concept was ahead of public opinion, and especially of opinion in the medical profession.

Biggs had realized that the next step in the development of community health services required a coalescence of preventive and curative medicine. Since 1920, this seminal concept has evolved in several directions. Among these the idea of comprehensive group practice coupled with prepayment, as exemplified by the Kaiser-Permanente Foundation and the Health Insurance Plan of Greater New York, has been demonstrated as practicable. Another approach was promoted by Joseph W. Mountin, of the U. S. Public Health Service, based on his belief that hospitals and health departments must eventually combine or coordinate their facilities and resources to provide a comprehensive health service for the communities they serve. As part of such a plan, he proposed to correlate the health center with the general hospital in the community.

After 1946, following the passage of the Hill-Burton Act, there was a renewal of the earlier interest in the role of the health center. A proponent of the idea who tied it to regionalization was John B. Grant of the Rockefeller Foundation. In fact, in 1949, he pointed out that the health center of the future had not yet been established.[56] Nevertheless, such centers did not really take hold after the 1940s.

Why Did the Health Center Movement Decline?

The concept of a local health center had developed largely in response to the

circumstances and the needs of the urban poor, particularly the immigrants. From the time of the First World War, however, these elements were changing, especially during the decades of the twenties and the thirties. Consequently, the time setting in which the movement for local health centers emerged and became institutionalized is important for understanding its further development.

The cessation of immigration during the war years and the restrictive legislation of 1921 and 1924 were undoubtedly important factors in changing the circumstances of the foreign-born. As the flow of new immigrants was cut down to a trickle, the foreign-born and even more so their children adapted to American life under the influence of economic and educational factors.[57] As they moved up the economic ladder, there was an increasing tendency to move out of the areas of initial settlement and toward the periphery of the community. Between 1920 and 1930 there appeared to be a growing trend toward less clustering of the foreign-born in ethnic neighborhoods. Movements within the cities and towards suburbs scattered members of these groups in areas that were mixed. Many of those involved in this process were younger persons of the second generation, largely native-born, with a greater earning capacity than their parents or older families with few children below working age. Hand-in-hand with these changes went higher levels of schooling among the children of the foreign-born and a wider use of English by their parents, changes clearly reflected in the foreign language press of the period.

As this potential clientele for local health centers changed its character, it turned more and more to the use of private health care. This tendency was reinforced by the limited nature of the services provided in most local health centers. Thus, there was practically no integration of preventive and curative services. As Michael Davis saw in 1921, "curative work furnishes the best approach to preventive" service. "In the field of preventive medical and health work," he said, "there is particular need for emphasizing . . . that the study of people must run parallel to the study of technique. As a corollary to this, curative work must be connected with preventive work, so that the service which the people seek of their own initiative can be supplemented by the service which we believe the larger interests of all require."[58] Therapeutic services were provided only to a limited degree, for the most part to patients with tuberculosis and venereal disease. At the same time medical practice was changing. Immunization, antepartum care and well child care were incorporated into the work of the private practitioner, and this was to happen later with the treatment of tuberculosis and venereal disease when the antibiotics became available.

The depression of the 1930s retarded these tendencies, but they were reinforced indirectly as the attention of many concerned with the provision of medical care and its costs turned to the problem of organizing the financing of such care on a compulsory or voluntary basis. The improvement of economic conditions toward the end of the decade coincident with the outbreak of World War II made it financially possible for more people to seek private medical care, especially when labor-management negotiations provided varying forms of health insurance. Thus, the local health centers tended to lose one part of the rationale for their creation.

The same period also saw the erosion of another part of the theoretical underpinning of the health center movement. Need for coordination of health and welfare services had been adduced as a reason for bringing them together under one roof or at least in close contiguity. However, the role of social agencies

changed greatly during the depression as government, particularly on the Federal level, assumed a larger and more active part in welfare, specifically in its financial aspects. At the same time social work was beginning to move away from an interest in social problems and reform. Case work became the dominant facet of social work, and in turn social work focused on the individual, on his personal strengths and weaknesses, and on individual psychological mechanisms, with psychoanalysis providing a theoretical rationale for this orientation.[59] Along this line of development, social agencies withdrew from health centers to other locations where they could centralize their therapeutic services and utilize them more efficiently.

In addition to the factors discussed above, there were a number of others that hindered the development of health centers and led to the decline of the movement. Thus, despite the often expressed aim of involving the local population in the neighborhood health program, this goal was hardly realized and remained more of a pious intention. Although Bellevue-Yorkville in New York City may have been envisaged as an experiment to crystallize community consciousness around health as a center, the demonstration was actually run by a group of voluntary health and welfare agencies, financed by a foundation in collaboration with the municipal health department.[60] In the New Haven Health Center Demonstration (1920–1923), efforts to develop active participation by local people were admittedly unsuccessful, mainly because the necessary rapport was not established with the largely Italian population.[61]

Another negative factor was the resistance by political forces in the broadest sense. The ability of government (municipal or state) to hinder or to facilitate the creation and development of health center programs is evident from the examples of Milwaukee, Cincinnati, and New York. Antagonism of professional groups such as physicians or welfare agencies were significant in some cases. Administrative infighting within the municipal health department was a factor in weakening the New York City health center program, and such a factor may have been operative elsewhere. Finally, one should note that the health center movement participated in the general pattern of development of public health during this period. In the late 1930s public health was beginning to approach the end of a period of development that had begun around the first decade of the century. World War II was an interlude in this transition which is still in process. By that time, however, the health center movement had run out of steam.

Questions?

Analysis of the earlier health center movement raises certain questions about the current neighborhood health centers. These too have come into being to provide for the needs of the urban poor, of people who have migrated to the city and who live under circumstances highly adverse to health. These centers clearly fill an immediate need, and no doubt fulfill their purpose better than did the earlier centers.[62] Today they are located in impoverished areas. But what should happen if and when the economic status of the population changes? One aim of the centers is job training, which implies a change in economic condition. Is it not possible that improved economic circumstances may lead to a shift of population, and thus to a loss of health center clientele? Or is there an unexpressed assumption that the poor will always be with us and a separate system is needed for them? Furthermore, should neighborhood centers remain purely local, or should they become part of a larger system of health care toward which we appear to be moving? Should

they become part of a national health insurance system and of a larger health-care delivery system? Obviously, such questions have no immediate answer, but they do arise from a consideration of the earlier local health center movement.

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This paper is also based in part on the author's experience as a clinic diagnostician in the Bureau of Tuberculosis, as a district health officer and Borough health officer in the Office of District Health Administration, and as the director of the Bureau of Health Education in the New York City Department of Health (1940–1943; 1946–1950).

Annual Meeting Makes Points

The 99th Annual Meeting of the American Public Health Association, to be held in Minneapolis, October 10–15, has been approved for the awarding of retirement points to reserve Army personnel, according to a directive from the Office of the Army Surgeon General. Any reservists who attend the meeting must complete DA Form 1380 and forward it to their appropriate headquarters in order to receive credit.